I

104TH CONGRESS
1ST SESSION

H. R. 1707

To amend title XVIII of the Social Security Act to ensure access to services and prevent fraud and abuse for enrollees of health maintenance organizations under the medicare program, to amend standards for medicare supplemental policies, to modify the medicare select program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 24, 1995

Mr. STARK (for himself, Mr. WAXMAN, Mr. ACKERMAN, Mr. COYNE, Mr. DELLUMS, Mr. FOGLIETTA, Mr. GONZALEZ, Mr. KENNEDY of Rhode Island, Mr. MCDERMOTT, Mr. OLVER, Mr. PALLONE, Ms. PELOSI, Mr. RANGEL, and Ms. WOOLSEY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

---

A BILL

To amend title XVIII of the Social Security Act to ensure access to services and prevent fraud and abuse for enrollees of health maintenance organizations under the medicare program, to amend standards for medicare supplemental policies, to modify the medicare select program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Beneficiary Protection Amendments of 1995''.

SEC. 2. REFERENCES IN ACT; TABLE OF CONTENTS.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—PROTECTIONS FOR BENEFICIARIES ENROLLED IN HEALTH MAINTENANCE ORGANIZATIONS

Subtitle A—Access to Services

SEC. 101. REQUIREMENTS RELATING TO PROVIDERS OF HEALTH SERVICES.

(a) DUE PROCESS PROTECTIONS FOR PROVIDERS.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

''(9)(A) In consultation with providers of health care services who are members of the organization's provider network, each eligible organization shall establish standards to be used by the organization for contracting with providers, and shall make descriptive information regarding these standards available to enrollees, providers who are members of the network, and prospective enrollees and prospective members of the network.

''(B)(i) An eligible organization may not terminate or refuse to renew an agreement with a provider of health care services to participate in the organization's provider network unless the organization provides written notification to the provider of the decision to terminate or refuse to renew the agreement. The notification shall include a statement of the reasons for the organization's decision, consistent with the standards established under subparagraph (A).

''(ii) The eligible organization shall provide the notification required under clause (i) at least 45 days prior to the effective date of the termination or expiration of the agreement (whichever is applicable). The previous sentence shall not apply if failure to terminate the agreement prior to the deadline would adversely affect the health or safety of an individual enrolled with the organization.

''(C)(i) Each eligible organization shall provide a process under which a provider of health care services may request a review of the organization's decision to terminate or refuse to renew the provider's participation agreement. Such review shall be conducted by a group of individuals the majority of whom are providers of health care services who are members of the organization's provider network or employees of the organization, and who are

members of the same profession as the provider who requests the review.

''(ii) If the provider requests in advance, the eligible organization shall permit an attorney representing the provider to be present at the provider's review.

''(iii) The findings and conclusions of a review under this subparagraph shall be advisory and non-binding.

''(iv) Nothing in this subparagraph shall be construed to affect any other provision of law that provides an appeals process or other form of relief to a provider of health care services.

''(D) The term 'provider network' means, with respect to an eligible organization, providers of health care services provided by or through the organization who have entered into an agreement with the organization under which the providers are obligated to provide such services to individuals enrolled with the organization.''.

(b) UTILIZATION REVIEW.—

(1) IN GENERAL.—Section 1876(c) (42 U.S.C. 1395mm(c)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(10)(A) An eligible organization may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets

the standards established by the Secretary under this paragraph.

''(B) The Secretary shall establish standards for utilization review programs of eligible organizations, consistent with subparagraph (C), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

''(C) Under the standards established under subparagraph (B)—

''(i) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage;

''(ii) negative determinations of the medical necessity or appropriateness of services or the site at which services are furnished may be made only by clinically qualified personnel;

''(iii) the utilization review program shall provide for a process under which an enrollee or provider may obtain timely review of a denial of coverage;

''(iv) utilization review shall be conducted in accordance with uniformly applied standards that are based on the most currently available medical evidence; and

''(v) providers shall participate in the development of the utilization review program.''.

(2) PROVIDING ENROLLEES WITH DESCRIPTION OF REQUIREMENTS.—Section 1876(c)(3)(E) (42 U.S.C. 1395mm(c)(3)(E)) is amended—

(A) by striking ''and'' at the end of clause (iv);

(B) by striking the period at the end of clause (v); and

(C) by adding at the end the following new clause:

''(vi) the organization's utilization review requirements.''.

(c) ACCESS TO CENTERS OF EXCELLENCE.—Section 1876(c) (42 U.S.C. 1395mm(c)), as amended by subsections (a) and (b), is amended by adding at the end the following new paragraph:

''(11)(A) Each eligible organization shall demonstrate that individuals enrolled with the plan who have chronic diseases or otherwise require specialized services have access through the organization to specialized treatment expertise of designated centers of excellence. The organization shall demonstrate such access according to standards developed by the Secretary, including require-

ments relating to arrangements with such centers and referral of enrollees to such centers.

''(B) The Secretary shall establish a process for the designation of facilities as centers of excellence for purposes of this paragraph. A facility may not be designated unless the facility is determined—

''(i) to provide specialty care,

''(ii) to deliver care for complex cases requiring specialized treatment and for individuals with chronic diseases, and

''(iii) to meet other requirements that may be established by the Secretary relating to specialized education and training of health professionals, participation in peer-reviewed research, or treatment of patients from outside the geographic area of the facility.''.

(d) RECOGNITION OF TRAUMA CENTERS.—Section 1876(c)(4) (42 U.S.C. 1395mm(c)(4)) is amended—

(1) in subparagraph (B), by inserting after ''organization'' the following: ''(including trauma services provided by designated trauma centers)''; and

(2) by adding at the end the following sentence: ''In subparagraph (B), a 'designated trauma center' has the meaning given such term in section 1231 of the Public Health Service Act, and includes a trau-

ma center which the Secretary finds meets the standards under section 1213 of such Act to be a designated trauma center but is located in a State that has not designated trauma centers under such section.''.

(e) NO REFERRAL REQUIRED FOR OBSTETRICS AND GYNECOLOGY.—Section 1876(c) (42 U.S.C. 1395mm(c)), as amended by subsections (a), (b), and (c), is amended by adding at the end the following new paragraph:

''(12) An eligible organization may not require an individual to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.''.

(f) COVERAGE OF SERVICES OF ESSENTIAL COMMUNITY PROVIDERS.—Section 1876(c) (42 U.S.C. 1395mm(c)), as amended by subsections (a), (b), (c), and (e), is amended by adding at the end the following new paragraph:

''(13)(A) For purposes of paragraph (4)(A), the Secretary may require an eligible organization to enter into agreements with essential community providers serving the organization's service area to join the organization's provider network (as defined in paragraph (9)(D)) if the Secretary finds that such agreements are necessary for the

organization to meet the requirements of such subparagraph.

''(B) In subparagraph (A), an 'essential community provider' means a rural health clinic (described in section 1861(aa)(2)), a Federally qualified health center (described in section 1861(aa)(4)), and any other provider meeting such standards as the Secretary may require.''.

(g) ACCESS TO EMERGENCY CARE SERVICES.—Section 1876(c)(4)(B) (42 U.S.C. 1395mm(c)(4)(B)), as amended by subsection (d), is further amended—

(1) by inserting ''emergency'' before ''services'' the first place it appears;

(2) by striking '', if (i)'' and all that follows through ''the organization''; and

(3) by adding at the end the following new sentence: ''In such subparagraph, 'emergency services' are services provided to an individual after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by a prudent layperson (possessing an average knowledge of health and medicine) to result in placing the individual's health in serious jeopardy, the serious impairment of a bodily function, or the serious dysfunction

of any bodily organ or part, and includes services provided as a result of a call through the 911 emergency system.''.

SEC. 102. DEADLINE FOR RESPONDING TO REQUESTS FOR COVERAGE OF SERVICES.

Section 1876(c)(5) (42 U.S.C. 1395mm(c)(5)) is amended by adding at the end the following new subparagraph:

''(C) In addition to the procedures available pursuant to subparagraph (A), in the case of the request of a member enrolled with an eligible organization for health services—

''(i) the eligible organization shall respond to the request not later than 24 hours after the request is made; and

''(ii) the organization shall hear and resolve a member's appeal of a denial of coverage of such services in accordance with a process meeting standards established by the Secretary.''.

SEC. 103. REQUIREMENTS FOR ORGANIZATION SERVICE AREAS.

(a) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new subsection:

''(k)(1) Except as provided in paragraph (2), for purposes of this section, if an eligible organization's service area includes any part of a metropolitan statistical area, the service area shall include the entire metropolitan statistical area (including any area designated by the Secretary as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act within such metropolitan statistical area).

''(2) The Secretary may permit an organization's service area to exclude any portion of a metropolitan statistical area (other than the central county of such metropolitan statistical area) if—

''(A) the organization demonstrates that it lacks the financial or administrative capacity to serve the entire metropolitan statistical area; and

''(B) the Secretary finds that the composition of the organization's service area does not reduce the financial risk to the organization of providing services to enrollees because of the health status or other demographic characteristics of individuals residing in the service area (as compared to the health status or demographic characteristics of individuals residing in the portion of the metropolitan statistical area not included in the organization's service area).''.

(b) CONFORMING AMENDMENT.—Section 1876(c)(4)(A)(i) (42 U.S.C. 1395mm(c)(4)(A)(i)) is amended by striking ''the area served by the organization'' and inserting ''the organization's service area''.

SEC. 104. OTHER ENROLLEE PROTECTIONS.

(a) CLARIFICATION OF RESTRICTIONS ON CHARGES FOR OUT-OF-PLAN SERVICES.—

(1) INPATIENT HOSPITAL AND EXTENDED CARE SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended in the matter preceding clause (i) by inserting after ''this title'' the following: ''(without regard to whether or not the services are furnished on an emergency basis)''.

(2) PHYSICIANS' SERVICES AND RENAL DIALYSIS SERVICES.—Section 1876(f)(2) (42 U.S.C. 1395mm(f)(2)) is amended by striking ''this section'' and inserting ''this section (without regard to whether or not the services are furnished on an emergency basis)''.

(b) ARRANGEMENTS FOR DIALYSIS SERVICES.—Section 1876(c) (42 U.S.C. 1395mm(c)), as amended by subsections (a), (b), (c), (e), and (f) of section 101, is amended by adding at the end the following new paragraph:

''(14) Each eligible organization shall assure that enrollees requiring renal dialysis services who are tempo-

rarily outside of the organization's service area (within the United States) have reasonable access to such services by—

''(A) making such arrangements with providers of services or renal dialysis facilities outside the service area for the coverage of and payment for such services furnished to enrollees as the Secretary determines necessary to assure reasonable access; or

''(B) providing for the reimbursement of any provider of services or renal dialysis facility outside the service area for the furnishing of such services to enrollees.''.

SEC. 105. REQUIRING PLANS TO PROVIDE EXPANDED SERVICES.

(a) IN GENERAL.—The first sentence of section 1876(c)(2)(A) (42 U.S.C. 1395mm(c)(2)(A)) is amended—

(1) by striking ''(I)'' and inserting ''(III)'';

(2) by striking ''and (II)'' and inserting ''(IV)'';

(3) by inserting after ''except that'' the following: ''(I) the organization shall provide members entitled to benefits under part A with inpatient hospital services under this title without regard to any limitation on the number of days of coverage otherwise applicable under section 1812 and with ex-

tended care services under this title without regard to whether or not such services are post-hospital extended care services, (II) the organization may not impose any cost-sharing with respect to the services it provides which are covered under this title or are described in subclause (I) unless the amount imposed is nominal (in accordance with standards established by the Secretary),''; and

(4) by striking the period at the end and inserting the following: '', and (V) the organization may not discontinue coverage of any such additional health care services unless the organization provides enrollees with reasonable notice that the services are to be discontinued.''.

(b) PROVIDING ENROLLEES WITH INFORMATION ON ADDITIONAL COVERED SERVICES.—Section 1876(c)(3)(E) (42 U.S.C. 1395mm(c)(3)(E)), as amended by section 101(b)(2), is amended—

(1) by striking ''and'' at the end of clause (v);

(2) by striking the period at the end of clause (vi) and inserting '', and''; and

(3) by adding at the end the following new clause:

''(vii) the services provided by the organization which are not covered under this title, including any

limits imposed by the organization on the provision of such services.''.

(c) CONFORMING CALCULATION OF ADJUSTED COMMUNITY RATE.—Section 1876(g)(2)(A) (42 U.S.C. 1395mm(g)(2)(A)) is amended by striking ''parts)'' and inserting the following: ''parts and taking into account the expanded inpatient hospital services, extended care services, and nominal cost-sharing the organization is required to provide under subsection (c)(2)(A))''.

SEC. 106. OUTLIER PAYMENTS.

(a) GENERAL RULE.—Section 1876(a)(1) (42 U.S.C. 1395mm(a)(1)) is amended by adding at the end the following:

''(G)(i) In the case of an eligible organization with a risk-sharing contract, the Secretary may make additional payments to the organization equal to not more than 50 percent of the imputed reasonable cost (or, if so requested by the organization, the reasonable cost) above the threshold amount of services covered under parts A and B and provided (or paid for) in a year by the organization to any individual enrolled with the organization under this section.

''(ii) For purposes of clause (i), the 'imputed reasonable cost' is an amount determined by the Secretary on

a national, regional, or other basis that is related to the reasonable cost of services.

''(iii) For purposes of clause (i), the 'threshold amount' is an amount determined by the Secretary from time to time, adjusted by the geographic factor utilized in determining payments to the organization under subparagraph (C) and rounded to the nearest multiple of $100, such that the total amount to be paid under this subparagraph for a year is estimated to be 5 percent or less of the total amount to be paid under risk-sharing contracts for services furnished for that year.

''(iv) An eligible organization shall submit a claim for additional payments under subsection (i) within such time as the Secretary may specify.

''(v) To the extent that total payments under clause (i) in a year—

''(I) exceed the payment set aside as a result of the reduction under subparagraph (C) for the year, the Secretary shall increase the percentage reduction under such subparagraph for the following year by such percentage as will result in an increase in the reduction equal to such excess in previous payments, or

''(II) are less than the payment set aside as a result of the reduction under subparagraph (C) for

the year, the amount of such difference shall remain available in the succeeding years for additional payments under this subparagraph and the Secretary may take such difference into account in establishing the percentage reduction under subparagraph (C) for the following year.''.

(b) CONFORMING AMENDMENT.—Section 1876(a)(1)(C) (42 U.S.C. 1395mm(a)(1)(C)) is amended by inserting '', reduced by a uniform percentage (determined by the Secretary for a year, subject to adjustment under subparagraph (G)(v)) so that the total reduction is estimated to equal the amount to be paid under subparagraph (G)'' before the period.

SEC. 107. DEMONSTRATION PROJECT ON COMPETITIVE RATE SETTING.

The Secretary of Health and Human Services shall conduct a demonstration project in not more than 4 metropolitan statistical areas under which—

(1) eligible organizations under section 1876 of the Social Security Act with enrollees residing in such areas shall participate in a competitive bidding process established by the Secretary;

(2) the amount of payment made to such organizations under section 1876 of such Act shall be de-

termined in accordance with a methodology which takes such bids into account; and

(3) an eligible organization may not enter into a risk-sharing contract under section 1876 of such Act with respect to such enrollees unless the organization agrees to accept the payment amount determined pursuant to paragraph (1) as the amount paid to the organization under such section.

Subtitle B—Protections Against Fraud and Abuse

SEC. 111. INTERMEDIATE SANCTIONS FOR PROGRAM VIOLATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

''(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

''(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—(A) Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1996, the Secretary of Health and Human Services shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act.

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876(b) of such Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such

entities is used by the Secretary of Health and Human Services to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1996, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

SEC. 112. TREATMENT OF HEALTH CARE PREPAYMENT PLANS.

(a) APPLICABILITY OF REQUIREMENTS FOR PLANS.—Section 1833(a)(1)(A) (42 U.S.C. 1395l(a)(1)(A)) is amended by inserting after ''prepayment basis'' the following: ''and which meets the requirements of subsection (t)''.

(b) REQUIREMENTS DESCRIBED.—Section 1833 (42 U.S.C. 1395l), as amended by section 160(d)(1) of the Social Security Act Amendments of 1994, is amended by adding at the end the following new subsection:

''(t)(1) For purposes of subsection (a)(1)(A), an organization meets the requirements of this subsection for a year if the organization—

''(A) meets solvency standards established by the Secretary'';

''(B) meets requirements established by the Secretary for the marketing of its plan to beneficiaries; and

''(C) is not an eligible organization with a contract in effect for the year under section 1876.

''(2) If the Secretary finds that an organization fails to meet the requirements described in paragraph (1), the Secretary may terminate the organization's contract under this section or impose any of the intermediate sanctions or remedies described in section 1876(i)(6) on the organization in the same manner as the Secretary may terminate a contract with an eligible organization under section 1876(i) or impose such sanctions or remedies on an eligible organization under section 1876(i)(6).''.

(c) REPEAL OF APPLICATION OF MEDIGAP STANDARDS.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)), as amended by section 171(f)(1) of the Social Security Act Amendments of 1994, is amended by striking '', or, during the period'' and all that follows through ''section 1833(a)(1)(A)''.

SEC. 113. PROVIDING ENROLLEES WITH CERTAIN INFORMATION ON PLANS.

(a) INFORMATION ON PHYSICIAN INCENTIVE PLANS.—

Section 1876(i)(8)(A) (42 U.S.C. 1395mm(i)(8)(A)) is amended by adding at the end the following new clause:

''(iv) Upon the request of an enrollee of the organization or an individual considering enrollment with the organization, the organization shall provide the enrollee with descriptive information regarding the physician incentive plan.''.

(b) INFORMATION ON PROVIDER CREDENTIALS.—Section 1876(c)(3)(E) (42 U.S.C. 1395mm(c)(3)(E)), as amended by section 101(b)(2) and section 105(b), is amended—

(1) by striking ''and'' at the end of clause (vi);

(2) by striking the period at the end of clause (vii) and inserting '', and''; and

(3) by adding at the end the following new clause:

''(viii) the credentials of the individuals and entities providing services to enrollees.''.

SEC. 114. RESTRICTIONS ON COMMISSIONS FOR AGENTS.

Section 1876(c) (42 U.S.C. 1395mm(c)), as amended by paragraphs (1), (2), (3), (5), and (6) of subsection (a)

and section 104(b), is amended by adding at the end the following new paragraph:

''(15) In the case of an eligible organization which employs agents to enroll individuals under this section and which pays an agent a commission with respect to the enrollment of an individual—

''(A) such commissions may not constitute the predominant source of the agent's total compensation from the organization (in accordance with standards established by the Secretary); and

''(B) if an agent receives a commission from the organization with respect to an individual who enrolls with the organization and the individual terminates enrollment with the organization during the 90-day period beginning on the date of the individual's enrollment, the organization shall recoup the commission from the agent.''.

SEC. 115. RESTRICTIONS ON IN-PERSON ENROLLMENT.

Section 1876(c)(3) (42 U.S.C. 1395mm(c)(3)) is amended by adding at the end the following new subparagraph:

''(H) Each eligible organization shall permit an individual entitled to benefits under part A to obtain enrollment forms and information and to enroll under this section by mail, and no agent of an eligible organization may

visit the residence of such an individual for purposes of enrolling the individual under this section or providing enrollment information to the individual other than at the individual's request.''.

SEC. 116. APPLICATION OF PEER REVIEW TO COST-BASED HEALTH MAINTENANCE ORGANIZATIONS AND HEALTH CARE PRE-PAYMENT PLANS.

Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended—

(1) by striking ''risk-sharing'';

(2) by inserting after ''this section'' the following: ''and each contract with an organization described in section 1833(a)(1)(A)''; and

(3) by striking ''eligible'' the second and third place it appears.

Subtitle C—Effective Date

SEC. 121. EFFECTIVE DATE.

The amendments made by this title shall apply with respect to contract years beginning on or after January 1, 1997.

TITLE II—PROTECTIONS FOR BENEFICIARIES ENROLLED IN MEDICARE SUPPLEMENTAL AND MEDICARE SELECT POLICIES

SEC. 201. CHANGES IN REQUIREMENTS FOR MEDICARE SUPPLEMENTAL POLICIES.

(a) REQUIREMENT OF COMMUNITY RATING.—

(1) IN GENERAL.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(A) in paragraph (3), by striking ''and (2)'' and inserting '', (2), and (3)'', and by redesignating such paragraph as paragraph (4), and

(B) by inserting after paragraph (2) the following new paragraph:

''(3)(A) Except as provided in this paragraph, the issuer of a medicare supplemental policy may not vary the premium among individuals who reside in the same community rating area.

''(B)(i) In the first year for which this paragraph applies to such an issuer in a State, the premium rate charged by the issuer for such a policy in a community may vary so long as the premium range percentage (as defined in clause (iii)) does not exceed ⅔ of the premium

range percentage of premium rates charged by the insurer for such policies in the community rating area in the previous year.

''(ii) In the second year for which this paragraph applies to such an issuer in a State, the premium rate charged by the issuer for such a policy in a community may vary so long as the premium range percentage (as defined in clause (iii)) does not exceed ½ of the maximum premium range percentage permitted under clause (i) for the previous year.

''(iii) In this paragraph, the term 'premium range percentage' means—

''(I) the highest premium rate minus the lowest premium rate, divided by

''(II) the lowest premium rate,

expressed as a percentage.

''(C) For purposes of this paragraph, each of the following is considered to be a separate 'community rating area':

''(1) Each metropolitan statistical area.

''(2) The area of each State that is not within a metropolitan statistical area.

(2) CONFORMING AMENDMENT.—Section 1882(s)(2)(A) (42 U.S.C. 1395ss(s)(2)(A)) is

amended by striking ‘‘, or discriminate in the pricing of the policy,’’.

(b) INCREASE IN LOSS RATIO.—Section 1882(r)(1)(A) (42 U.S.C. 1395ss(r)(1)(A)) is amended by striking ‘‘75 percent’’ and all that follows through the semicolon and inserting ‘‘85 percent;’’.

(c) EFFECTIVE DATE.—

(1) NAIC STANDARDS.—If, within 6 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this section referred to as the ‘‘NAIC’’) makes changes in the 1991 NAIC Model Regulation (as defined in section 1882(p)(1)(A) of the Social Security Act) to incorporate the additional requirements imposed by the amendments made by this section, section 1882(g)(2)(A) of such Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed under this section (such changed Regulation referred to in this section as the ‘‘1995 NAIC Model Regulation’’).

(2) SECRETARY STANDARDS.—If the NAIC does not make changes in the 1991 NAIC Model Regulation (as so defined) within the 6-month period specified in paragraph (1), the Secretary of Health and Human Services (in this subsection as the ''Secretary'') shall promulgate a regulation and section 1882(g)(2)(A) of the Social Security Act shall be applied in each State, effective for policies issued to policyholders on and after the date specified in paragraph (3), as if the reference to the Model Regulation adopted in June 6, 1979, were a reference to the 1991 NAIC Model Regulation (as so defined) as changed by the Secretary under this subsection (such changed Regulation referred to in this subsection as the ''1995 Federal Regulation'').

(3) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State adopts the 1995 NAIC Model Regulation or the 1995 Federal Regulation; or

(ii) 1 year after the date the NAIC or the Secretary first adopts such regulations.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the 1995 NAIC Model Regulation or the 1995 Federal Regulation, but

(ii) having a legislature which is not scheduled to meet in 1996 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1996. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 202. APPLICATION OF STANDARDS TO MEDICARE SELECT POLICIES.

Section 1882(t) (42 U.S.C. 1395ss(t)) is amended—

(1) in the matter in paragraph (1) before subparagraph (A), by inserting ‘‘, under the standards established under paragraph (4)’’ after ‘‘if’’;

(2) by striking ‘‘and’’ at the end of paragraph (1)(E);

(3) by striking the period at the end of paragraph (1)(F) and inserting a semicolon;

(4) by adding at the end of paragraph (1) the following new subparagraphs:

‘‘(G) notwithstanding any other provision of this section to the contrary, if the issuer of the policy meet the requirements of paragraph (5).’’;

(5) by adding at the end of paragraph (2) the following: ‘‘The intermediate sanctions described in clauses (ii) and (iii) of section 1876(i)(6)(B) shall apply to actions described in the first sentence of this paragraph in the same manner as they apply to violations described in section 1876(i)(6)(A).’’; and

(6) by adding at the end the following new paragraphs:

‘‘(4)(A) The Secretary shall establish by regulation standards for policies in order to be provided special treatment under paragraph (1). To the extent practicable, such standards shall be the same as the standards established

by the National Association of Insurance Commissioners with respect to such policies. Any additional standards shall be developed in consultation with such Association.

''(B) If the Secretary determines that a State has established an effective program to enforce the standards established under subparagraph (A), any policy that a State determines under such program to meet such standards shall be deemed to meet such standards for purposes of this section.

''(5) For purposes of paragraph (1), the requirements of this paragraph, with respect to a policy are as follows:

''(A) If the issuer of the policy—

''(i) is an eligible organization (as defined in section 1876(a)), the benefits under the policy (in coordination with benefits made available under this title) are the same as the benefits required to be made available by such an organization with a risk-sharing contract under section 1876, or

''(ii) is not such an organization, the benefits under the policy shall be either—

''(I) the benefits required under the Standardized Medicare supplement benefit plan 'E' (as specified in section 9E(5) of the 1991 NAIC Model Regulation), plus

One Hundred Percent (100%) of the Medicare Part B Excess Charges (as defined in section 8C(5) of such Regulation); or

''(II) the benefits required under the Standardized Medicare supplement benefit plan 'J' (as specified in section 9E(10) of such Regulation).

''(B) The issuer of the policy (in relation to the policy) meets the same requirements under section 1876 that would apply to an eligible organization with a risk-sharing contract under that section (including community rating of premiums and prior approval of marketing materials, but not including provision of benefits).''.

TITLE III—COORDINATION OF ENROLLMENT AND TERMINATION OF ENROLLMENT

SEC. 301. UNIFORM OPEN ENROLLMENT PERIODS.

(a) FOR CAPITATED PLANS.—

(1) ESTABLISHMENT.—The first sentence of section 1876(c)(3)(A)(i) (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended by inserting ''(which shall be specified by the Secretary)'' after ''open enrollment period''.

(2) PERIOD FOR TERMINATION OF ENROLLMENT.—Section 1876(c)(3)(B) (42 U.S.C. 1395mm(c)(3)(B)) is amended to read as follows:

''(B)(i) Except in the case of an individual terminating enrollment for cause, an individual may terminate enrollment with an eligible organization under this section only during the open enrollment period described in subparagraph (A)(i), except as follows:

''(I) For the first 12-month period during which the individual is enrolled with the organization, the individual may terminate enrollment during the final month of each calendar quarter occurring during such period.

''(II) For the second year in which the individual is enrolled with the organization, the individual may terminate enrollment during the final month of the second calendar quarter.

''(III) In the case of an eligible organization with a reasonable cost reimbursement contract or an organization which is financially insolvent, the individual may terminate enrollment in accordance with regulations prescribed by the Secretary.

''(ii) An individual's termination of enrollment shall be effective as of the beginning of the first calendar month following the date on which the individual requests such

termination (or, in the case of an organization with a reasonable cost reimbursement contract or an organization which is financially insolvent, as may be prescribed by the Secretary in regulations).

''(iii) If an individual terminates enrollment with an eligible organization, the organization shall provide the individual with a copy of the written request for termination and a written explanation of the period (ending on the effective date of the termination under clause (ii)) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.''.

(b) FOR MEDIGAP PLANS.—Section 1882(s) (42 U.S.C. 1395ss(s)), as amended by section 201(a)(1), is amended—

(1) in paragraph (4), by striking ''and (3)'' and inserting '', (3), and (4)'', and by redesignating such paragraph as paragraph (5), and

(2) by inserting after paragraph (3) the following new paragraph:

''(4)(A) Each issuer of a medicare supplemental policy shall have an open enrollment period (which shall be the period specified by the Secretary under section 1876(c)(3)(A)(i)), of at least 30 days duration every year, during which the issuer may not deny or condition the is-

suance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of age, health status, claims experience, receipt of health care, or medical condition. The policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods (except as provided by paragraph (2)(B)). The Secretary may require enrollment through a third party designated under section 1876(c)(3)(B).

''(B) The provisions of section 1876(c)(3)(B) shall apply with respect to the termination of enrollment with the issuer of a medicare supplemental policy in the same manner as such provisions apply with respect to the termination of enrollment with an eligible organization under section 1876.''.

(c) FOR MEDICARE SELECT POLICIES.—Section 1882(t)(5) (42 U.S.C. 1395ss(t)(5)), as added by section 202(a)(6), is amended by adding at the end the following new subparagraph:

''(C) The periods for enrollment and termination of enrollment applicable for the policy are the same periods applicable to a medicare supplemental policy under section 1882(s)(4).''.

SEC. 302. ENROLLMENTS FOR NEW MEDICARE BENEFICIARIES AND THOSE WHO MOVE.

Section 1876(c)(3)(A) (42 U.S.C. 1395mm(c)(3)(A)) is amended—

(1) in clause (i), by striking ''clause (ii)'' and inserting ''clauses (ii) through (iv)'', and

(2) by adding at the end the following:

''(iii) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) during any enrollment period specified by section 1837 that applies to that individual. Enrollment under this clause shall be effective as specified by section 1838.

''(iv) Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (d) who has previously resided outside the geographic area which the organization serves. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that geographic area and shall end at the end of the following month. Enrollment under this clause shall be effective as of the first of the month following the month in which the individual enrolls.''.

SEC. 303. PROVISION BY SECRETARY OF ENROLLMENT INFORMATION AND OTHER INFORMATION ON ELIGIBLE ORGANIZATIONS AND MEDICARE SUPPLEMENTAL POLICIES.

(a) IN GENERAL.—Section 1804(b) (42 U.S.C. 1395b–2(b)), as added by section 171(j)(1)(C) of the Social Security Act Amendments of 1994, is amended to read as follows:

''(b) The Secretary shall provide information upon request (including through the mails and via a toll-free telephone number) to any individual entitled to benefits under this title on the programs under this title, including—

''(1) information to assist individuals in enrolling with eligible organizations under section 1876 and in selecting among such organizations for enrollment, including information on the premiums charged by such organizations for enrollment; and

''(2) information on medicare supplemental policies under section 1882, including the relationship of State programs under title XIX to such policies and the premiums charged by such policies for enrollment (to the extent information on such premiums is available to the Secretary).''.

(b) CONFORMING AMENDMENT.—Section 1882(f) (42 U.S.C. 1395ss(f)), as added by section 171(j)(2) of the Social Security Act Amendments of 1994, is repealed.

SEC. 304. EFFECTIVE DATE.

The amendments made by this title apply to enrollments and terminations of enrollments occurring after 1996 (but only after the Secretary of Health and Human Services has prescribed the relevant annual period), except that the amendments made by section 301(b) apply to enrollments for a medicare supplemental policy made after 1996.

○

HR 1707 IH——2

HR 1707 IH——3

HR 1707 IH——4